

Idaho TB Contact Tracing Form—Return with CDC “Report of Verified Case of Tuberculosis Follow Up Report-2”

Case Name: _____ Year Reported: _____ Number of Contacts Identified: _____

List of contacts (use additional sheets if necessary):

Name	Relationship to Case (family, co-worker, etc.)	Date First Evaluated	PPD Tested?	PPD Result	CXR?	CXR Result	Infection status (uninfected, infected, active TB, or unknown)	Started on PPx? (INH or other)	Date PPx Started	Date PPx Last Taken	PPX Completed? If PPx not Completed, Reason*:
Bob Contact	Brother of case	01/01/2000	Y	10mm	Y	Negative	Infected	Y – INH	01/06/2000	05/06/2000	No. 2

*Reasons for not finishing PPx (pick the best option): 1. Death; 2. Moved AND unable to locate for follow-up; 3. Adverse effect of medication;
4. Contact chose to stop despite indication for continuation of PPx; 5. Contact lost to follow-up; 6. Provider decision

TB CONTACT INVESTIGATION REPORT

Page ____ of ____

Today's Date: _____

Submitted by: _____

Agency: _____

Contact Risk Factors: 1. Household contact; 2. Less than 5 yo; 3. Contact has med risk factor (HIV); 4. Exposed during medical procedure; 5. Exposed congregate setting; 6. Exceeds duration environment limits; 7. CXR consistent with previous TB; 8. 5-15yo of age

Case Name: _____ County/Tribal/ IHS: _____

List of Contacts: 1. Name 2. Relationship to TB case 3. Address	DOB	Contact Risk Factors And Dates (see above)	Initial TST		2 nd TST 8-10 weeks		X-Ray <small>If patient less than 5 years old, must have both posterior & lateral x-rays</small>		Treatment of LTBI		If Treatment is not completed give reason
			Date	Result mm	Date	Result mm	Date	Result	Med & Start Date	Completion Date	
1. _____ 2. _____ 3. _____											<input type="checkbox"/> Death <input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Patient Decision <input type="checkbox"/> Active TB developed <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved - provide address
1. _____ 2. _____ 3. _____											<input type="checkbox"/> Death <input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Patient Decision <input type="checkbox"/> Active TB developed <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved - provide address
1. _____ 2. _____ 3. _____											<input type="checkbox"/> Death <input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Patient Decision <input type="checkbox"/> Active TB developed <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved - provide address
1. _____ 2. _____ 3. _____											<input type="checkbox"/> Death <input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Patient Decision <input type="checkbox"/> Active TB developed <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved - provide address
1. _____ 2. _____ 3. _____											<input type="checkbox"/> Death <input type="checkbox"/> Adverse Reaction <input type="checkbox"/> Patient Decision <input type="checkbox"/> Active TB developed <input type="checkbox"/> Lost to follow-up <input type="checkbox"/> Moved - provide address

Tuberculosis Contact Investigation Form

Submitted By: _____

Date: _____

Case							Contact									
Name: (last) (first) (MI) (also known as)							Priority of exposed contact				Contact Investigation			Contact Risk Factors (Mark Y =Yes or N = No in chart below)		
DOB: Age: RVCT:							(please refer to CI Instructions for definitions)				Date Identified: _____ Date Interviewed: _____ Date of Evaluation: _____			1. Household 2. Less than 5 years of age 3. Contact has medical risk factor (i.e. HIV) 4. Exposed during medical procedure 5. Exposed congregate Setting 6. Exceeds duration environment limits 7. 5 - 15 years of age		
Morbidity Date:							<input type="checkbox"/> Category 1: Smear positive or cavitory chest x-ray <input type="checkbox"/> Category 2: Smear negative <input type="checkbox"/> Category 3: Suspect case									
County: Comments:																
Type: <input type="checkbox"/> Pulmonary <input type="checkbox"/> Non Pulmonary CXR Results: <input type="checkbox"/> Cavitory <input type="checkbox"/> Noncavitory																
Full Name of Contact	Date of Birth	*Exposure category	Household	< 5 years	Med risk	Medical exposure	Cong Set	Enviro limits	5 - 15 years	CXR- prev TB	TST Results/ QFT-G Results			Current Chest X-Ray	Treatment of LTBI	**** Completion Date or Discontinued Due to:
											Prior Positive	Initial TST or QFT-G *	8 - 10 week retest			
1.												Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	
2.												Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	
3.												Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	
4.												Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	
5.												Date: _____ TST mm: _____ QFT-G: _____	Date: _____ TST mm: _____ QFT-G: _____	Date: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<input type="checkbox"/> Yes Date: _____ Drug (s) _____ <input type="checkbox"/> No Reason: _____	

***Exposure Category**

H= High
M= Medium
L= Low

****Prior Positive**

(1) = Follow-up needed
(2) = Follow-up not needed

*****Quantiferon-GOLD Results**

(1) = Positive
(2) = Negative
(3) = Indeterminate

******Completion date or discontinued due to:**

(C) = Completed treatment
(D) = Died during treatment
(L) = Lost
(M) = Moved & Records Referred

(P) = Provider Discontinued Meds
(R) = Refused to continue
(T) = TB Disease Diagnosed

TB Contact Investigation Summary

Due at the completion of each contact investigation - After all contacts on treatment for LTBI have completed therapy or have discontinued drug therapy

Montana Department of Public Health & Human Services
TB Program, Cogswell Building, Room C-216
1400 Broadway, Helena, MT 59620
Phone: 406-444-0275; Fax: 406-444-0272

Today's Date _____
Submitted by _____
Date Case Reported _____
County _____

Case Name _____

1. The case had: _____ pulmonary TB with AFB sputum smear positive
(check one) _____ pulmonary TB with AFB sputum smear negative
_____ non-pulmonary TB
_____ other _____
2. Number of contacts identified _____
3. Number of contacts evaluated _____
(initial TST placed & read, follow-up TST placed & read if indicated, and chest x-ray)
4. Number of contacts that were diagnosed with active TB disease as a result of this contact investigation _____ (This will trigger a separate contact investigation.)
5. Number of contacts that were diagnosed with latent TB infection (LTBI) as a result of this contact investigation _____
 - a. Number that started treatment for LTBI _____
 - b. Number of contacts that completed recommended treatment _____
6. For contacts not completing treatment for LTBI:
 - a. Number who died before completing therapy _____
 - b. Number who moved before completing therapy with no follow-up information _____
 - c. Number who developed active TB disease during the course of therapy _____
 - d. Number who stopped treatment due to side effects/adverse reactions _____
 - e. Number who chose to stop treatment without any contraindications _____
 - f. Number who stopped treatment on provider's advice _____
 - g. Number lost to follow-up _____

Evaluation Indices for Contact Investigation:

1. Percentage of contacts evaluated _____ (MT goal: 95% of contacts to AFB-positive smear cases are evaluated)
2. Percentage of contacts who were diagnosed with LTBI _____
3. Percentage of contacts with LTBI who completed treatment _____ (MT goal: 80% of contacts with LTBI will complete treatment)